Methodist Children's Home
A Community of Hope and Healing

# PRTF APPLICATION AND ADMISSION ASSESSMENT FORM

**Admissions: Phone: 318-255-5020 Fax: 318-734-9060 Email: admissions@LMCH.org**

## YOUTH INFORMATION

Child's Full Legal Name: _____ Date of Birth: _____ Age: _____

Child's SSN: _____ JETS # (if OJJ custody) or TIPS # (if DCFS custody): _____

*Healthy Louisiana* Plan (MCO): ☐ Aetna Betterhealth ☐ AmeriHealth Caritas ☐ Louisiana Healthcare Connections
☐ United Health Care ☐ Humana Healthy Horizons ☐ Healthy Blue

Medicaid #: _____ *MCO Member ID #*: _____

Any other Insurance available? _____ Is the child emancipated, married, or has a child? ☐ Yes ☐ No

Allergies: _____

Sex: ☐Male ☐Female Height: _____ Weight: _____Ethnicity/Race: _____ Eye Color: _____ Hair Color: _____

Child's Current Placement: ☐ Parents ☐ Group Home ☐ Foster Home ☐ Detention ☐ Other: _____

Child's Current Placement Address: _____

City: _____ Parish: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Referring Agency (Hospital, Insurance, DCFS, OJJ, LDH, etc): _____ Phone #: _____

Contact Name: _____ Email: _____

Name the Adult(s) who have Custody of the Child *(please provide custody order if necessary)*:

Father: _____ Rights? Yes / No Hm# _____ Cell# _____ SSN: _____

Mother: _____ Rights? Yes / No Hm# _____ Cell# _____ SSN: _____

Other: _____ Rights? Yes / No Hm# _____ Cell# _____ SSN: _____

DCFS/OJJ: _____ How long has the child been in custody? _____

Have Parental Rights been Terminated for Biological Parents: ☐ Yes ☐ No (explain) _____

With whom is the child ***NOT*** permitted to have contact? (Legal documentation is required, ie. Court Order)

_____

***CURRENT FEMALE GUARDIAN***

***PLEASE CIRCLE ONE:*** ***MOTHER, AUNT, GRANDMOTHER, ADOPTIVE MOTHER, DCFS CASE WORKER, OJJ PROBATION OFFICER, OTHER***

Full Name: _____ DOB: _____ Occupation: _____

Street: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Alternate Phone: _____ Email: _____

***CURRENT MALE GUARDIAN***

***PLEASE CIRCLE ONE:*** ***FATHER, AUNT, GRANDFATHER, ADOPTIVE FATHER, DCFS CASE WORKER, OJJ PROBATION OFFICER, OTHER***

Full Name: _____ DOB: _____ Occupation: _____

Street: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Alternate Phone: _____ Email: _____

| Siblings' Names | Sex | Age or DOB | Lives with |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## CURRENT BEHAVIORS

Why is admission into a Psychiatric Residential Treatment Program required at this time? _____

_____

**RISK ASSESSMENT** (If marked "Yes" explain below)

Is there a risk or history of the child **attempting suicide**? ☐ Yes ☐ No

Is there a risk or history of the child **harming self**? ☐ Yes ☐ No

Is there a risk or history of the child **harming others**? ☐ Yes ☐ No

Is there a risk or history of the child **harming animals**? ☐ Yes ☐ No

Is there a risk or history of the child **starting fires**? ☐ Yes ☐ No

Is there a risk or history of the child **running away**? ☐ Yes ☐ No

Is there a risk or history of the child **using substances**? ☐ Yes ☐ No

Is there a risk or history of the child **acting out sexually**? ☐ Yes ☐ No

Do other **needs**, **legal charges**, **activities**, or **behaviors** put this child at special risk? ☐ Yes ☐ No

**Explain any items marked "Yes"** above with behaviors, dates of events, etc. (if substance use, specify type, frequency, amount, duration, last use, and drug screen results):_____

_____

_____

_____

## History of HEALTHY LOUISIANA Medicaid Funded Care

Has the child or family received services from a **Coordinated System of Care Agency (CSOC)**? ☐ Yes ☐ No

Has the child or family received services from a **Wrap Around Agency (WAA)**? ☐ Yes ☐ No

Has the child or family received services from a **Family Support Organization (FSO)**? ☐ Yes ☐ No

Has the child or family received services from a **Managed Care Organization case manager**? ☐ Yes ☐ No

Has the child or family received services from a **Child and Family Team**? ☐ Yes ☐ No

If "yes" to any above, name the organization and persons with whom you spoke: _____

**Has the child previously been a Methodist Children's Home resident?** ☐ Yes ☐ No

If Yes, when and where? _____

## TARGETED TREATMENT GOALS

What are the goals for treatment that a less intensive level of care cannot meet? _____

_____

_____

## PREVIOUS TREATMENT

Has the child received treatment from an Outpatient Therapist? ☐ Yes ☐ No

Name/Credentials: _____ Phone: _____

Start Date: _____ Last Appt: _____ Freq: Weekly Bi-Monthly Monthly Mode: Indiv Family Group

**Provide a History of the Child's Most Recent Psychiatric Hospitalizations and Out-of-Home Placements:**

PLEASE HAVE DOCUMENTS AVAILABLE FROM PSYCHIATRIC HOSPITALS: **Number of Psychiatric Hospitalizations**: _____

| Name and Type of Facility | Admit Date | Discharge Date | Reason for Placement |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## HISTORY OF ABUSE, NEGLECT AND CRIME VICTIMIZATION

Does the child have a history of **physical abuse**? ☐ Yes ☐ No
Does the child have a history of **sexual abuse**? ☐ Yes ☐ No
Does the child have a history of **mental/emotional abuse**? ☐ Yes ☐ No
Does the child have a history of **neglect**? ☐ Yes ☐ No
Does the child have a history of **exposure to domestic violence**? ☐ Yes ☐ No
Does the child have a history of **exposure to pornography**? ☐ Yes ☐ No
Does the child have a history of **exposure to adult sexual behavior**? ☐ Yes ☐ No
Does the child have a history of **sexually perpetrating against others**? ☐ Yes ☐ No
Does the child have a history of being a **victim of a crime**? ☐ Yes ☐ No
Does the child have a history of **other psychological trauma**? ☐ Yes ☐ No

**PLEASE** describe the **child's** history regarding any of the above questions marked "**Yes**".

_____

_____

_____

## Educational Information

**Last** School Attended: _____Parish:_____Grade: _____

School Address: _____ City: _____ State: _____

Zip: _____Full Scale IQ score if available: _____ List school behavior Strengths/weaknesses: _____

_____Does the child have a 504 or IEP plan? ☐ Yes ☐ No "If **Yes**, please **Circle** which plan."

Provide reason for 504 or IEP plan if applicable: _____

**Names of the Child's Doctors**

***Primary Care Physician***: _____ Phone: _____

Address: _____ Date Last Seen: _____

***Specialist***: _____ Phone: _____

Address: _____ Date Last Seen: _____

***Dentist***: _____ Phone: _____

Address: _____ Date Last Seen: _____

***Eye Doctor***: _____ Phone: _____

Address: _____ Date Last Seen: _____

**Current Psychiatric Diagnosis:** _____

**Date of Diagnosis:** _____ **Assessment Performed by:** DOCTOR'S NAME: _____

DSM diagnosis: _____

_____

**MEDICAL INFORMATION:** **Please List ALL Current Medications:**

| Name of Medication and Dosage, Route Frequency | Prescribed by: | Prescribed as Treatment for: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Is the child compliant with current prescribed medications? ☐ Yes ☐ No

Are the child's Immunizations Current? (Check one): ☐ Yes ☐ No Y*ou **MUST** provide a copy of the IMMUNIZATION RECORD.*

**Has the child EVER HAD or currently HAS any of the following? Check each item. If yes, specify and explain.**

*Please provide accurate information about your child's MEDICAL HISTORY.*

| | | | | | | |
|---|---|---|---|---|---|---|
| Anaphylaxis | ▫ Yes | ▫ No | | Hearing Impairment | ▫ Yes | ▫ No |
| Anemia | ▫ Yes | ▫ No | | Heart Murmur | ▫ Yes | ▫ No |
| Aneurysm | ▫ Yes | ▫ No | | High Cholesterol | ▫ Yes | ▫ No |
| Arrhythmia (heart) | ▫ Yes | ▫ No | | Hypertension (High Blood Pressure) | ▫ Yes | ▫ No |
| Arthritis | ▫ Yes | ▫ No | | Kidney Stones | ▫ Yes | ▫ No |
| Asthma | ▫ Yes | ▫ No | | Lupus | ▫ Yes | ▫ No |
| Back Pain/Injury | ▫ Yes | ▫ No | | Multiple Sclerosis | ▫ Yes | ▫ No |
| Bleeding Disorder | ▫ Yes | ▫ No | | Ovarian Cysts | ▫ Yes | ▫ No |
| Broken Bones | ▫ Yes | ▫ No | | Pancreatitis | ▫ Yes | ▫ No |
| Cancer | ▫ Yes | ▫ No | | Pneumonia | ▫ Yes | ▫ No |
| Chronic Pain | ▫ Yes | ▫ No | | Psoriasis | ▫ Yes | ▫ No |
| Concussions | ▫ Yes | ▫ No | | Reflux/Esophagitis | ▫ Yes | ▫ No |
| Crohn's Disease | ▫ Yes | ▫ No | | Renal Failure | ▫ Yes | ▫ No |
| Cystic Fibrosis | ▫ Yes | ▫ No | | Seizures/Convulsions | ▫ Yes | ▫ No |
| Diabetes | ▫ Yes | ▫ No | | Shunts of any kind | ▫ Yes | ▫ No |
| Eating Disorder | ▫ Yes | ▫ No | | Sickle Cell Anemia/ Sickle Cell Trait | ▫ Yes | ▫ No |
| Endometriosis | ▫ Yes | ▫ No | | Skin Problems/Chronic Rash/ Eczema | ▫ Yes | ▫ No |
| Epilepsy | ▫ Yes | ▫ No | | Sleep Apnea | ▫ Yes | ▫ No |
| Eye Problems | ▫ Yes | ▫ No | | Spina Bifida | ▫ Yes | ▫ No |
| Fainting | ▫ Yes | ▫ No | | Tumors | ▫ Yes | ▫ No |
| Gallstones | ▫ Yes | ▫ No | | Ulcers | ▫ Yes | ▫ No |
| Headaches | ▫ Yes | ▫ No | | Other | ▫ Yes | ▫ No |

Explain all "Yes" answers: _____

_____

_____

**Surgery: (If the child has ever had surgery for these conditions, check the box and write the date beside it.)**

| | | | |
|---|---|---|---|
| ○ Appendectomy | ○ Bone/Muscle | ○ Heart Surgery | ○ Ear Tubes |
| ○ Adenoidectomy | ○ Splenectomy | ○ Kidney Surgery | ○ Tonsillectomy |
| ○ Eye Surgery | ○ Gallbladder | ○ Brain Surgery | ○ Other |

**Medical Hospitalizations (*NON-PSYCHIATRIC*): Number of Previous Hospitalizations:** _____

| Name of Facility | Admit Date | Discharge Date | Reason for Medical Hospitalization |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Female Children ONLY**

Onset of menses: _____ Difficult/Painful Periods ☐ Yes ☐ No # of Pregnancies: _____

Birth Control: ☐ Pill ☐ Depo Shot – date last given _____ ☐ Implant – Placed on: _____

**Sexually Transmitted Diseases (Males AND Females):** Check the box and write the treatment date in the box if applicable.

| | | |
|---|---|---|
| ▫ HIV/Aids | ▫ HPV/Genital Warts | ▫ Chlamydia |
| ▫ Hepatitis A, B, or C | ▫ Herpes | ▫ Syphilis |
| ▫ Trichomoniasis | ▫ Gonorrhea | ▫ Other |

**STATEMENT OF APPLICATION FOR ADMISSION**

Name of Person Completing this Application: _____

Relationship to Child: _____ Date: _____

I (we), the undersigned Parent(s) or Legal Guardian(s), do hereby apply to Louisiana United Methodist Children and Family Services, Inc. for Psychiatric Residential Treatment Facility (PRTF) services for the child named above for whom I (we) hold legal custody and/or placement authority. I(we) certify the information provided in this PRTF Application and Admission Assessment Form and the attached documents is true and accurate to the best of my (our) knowledge. I(we) agree to share additional information related to this application as it becomes available and/or is requested by Louisiana United Methodist Children and Family Services. I (we) also agree to cooperate with LUMCFS to fully and actively support the child's plan of care, to which we mutually agree.

Does any other adult have legal rights to this child? ☐ Yes ☐No

If "Yes", please provide their name and explain: _____

**Signatures of Parent(s) or Legal Guardians(s) Requesting Child's Admission**

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Child

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Child

# www.LUMCFS.org/admissions